



# Montana Fish, Wildlife & Parks

<http://fwp.mt.gov>

## 2009 Permit To Hunt From A Vehicle

### Section 1 — Must be completed by the applicant

#### ALS = Automated Licensing System

- Montana hunting, fishing and other recreational licenses are issued via an automated licensing system (ALS).
- The first time you acquire a license through ALS, you will be assigned a **lifetime "ALS number"**.
- **The ALS number is your birthdate plus a number randomly issued by the automated system.**

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ ALS # \_\_\_\_ (see above)  
MM DD YYYY

Last 4 digits of your Social Security Number \_\_\_\_

**If you do not have an ALS number, you MUST also provide the last 4 digits of your social security number.**

MANDATORY

Name	First	MI	Last	Jr. Sr.	Home Phone ( ) -	Work Phone ( ) -
Mailing Address (Your application cannot be processed if you list only a PO Box Number)				Physical Address		
City			State	Zip Code	Country <input type="checkbox"/> USA <input type="checkbox"/> Other _____	
<input type="checkbox"/> Female	Weight	Height	Hair	Eyes	Occupation	
<input type="checkbox"/> Male						
<input type="checkbox"/> Yes (FWP receives requests for mailing lists. Do you want your name included on lists provided by FWP to requestors?) <input type="checkbox"/> No						

I hereby declare that all statements on this form are true and correct. I have not made more than one application per permit. I understand that if I subscribe to any false statement in this application I am subject to criminal prosecution. MCA 87-2-104.

**X** \_\_\_\_\_

SIGNATURE OF APPLICANT—Original Signature Required—Do Not Print  
(Faxed or photocopied signature not acceptable.)

\_\_\_\_\_ Date

### Section 2 and 3 — Must Be Completed - See Reverse Side of Application

**Section 3 must be completed by a licensed physician Medical (MD) or Osteopathic (DO), Advanced Practice Registered Nurse (APRN), or Licensed Physician Assistant (PA) only.**

#### Please Remember:

- This permit must be used with a valid current years hunting license.
- This permit is nontransferable.
- This permit is valid unless permit criteria changes.
- This permit is free-of-charge.
- Invalid or incomplete applications will be returned.
- Questions???s —Call (406) 444-2535

**Return completed application to:**  
**Montana Fish, Wildlife & Parks**  
**ATTN: Information Center**  
**1420 East 6th Avenue**  
**PO Box 200701**  
**Helena, MT 59620-0701**

#### Check Your Application:

- ☐ I have completely filled out MANDATORY Sections 1 and 2
- ☐ I have signed my application in both Sections 1 and 2.
- ☐ I have obtained the appropriate signatures from my health care provider in Section 3.

**LICENSES issued through the mail may take two weeks from time of receipt to process.**  
**Please allow adequate time.**

## Section 2 — Must be completed by the applicant

Hunters with the *Permit to Hunt From a Vehicle* authorization **MUST BE** accompanied by another person to assist with field dressing and/or recovery of a wounded game animal when hunting big game, MCA 87-2-803(4).

I (PRINT your name), \_\_\_\_\_ hereby affirm that I am capable of holding and firing legal firearms, without assistance from other persons, and that I qualify for this permit because:

**Applicant MUST check one or more of the following PERMANENT eligibility criteria**

I am permanently dependent on:

- ☐ 1. wheelchair for mobility
- ☐ 2. crutch for mobility
- ☐ 3. cane for mobility
- ☐ 4. an oxygen device

I am an:

- ☐ 5. amputee above the wrist  
and/or  
amputee above the ankle

I am permanently unable to:

- ☐ 6. walk, unassisted, 600 yards over rough and broken ground while carrying 15 pounds within 1 hour AND I am unable to handle and maneuver up to 25 pounds.

X \_\_\_\_\_

SIGNATURE OF APPLICANT - Original Signature Required - Do Not Print  
(Faxed or photocopied signature not acceptable.)

\_\_\_\_\_ Date

## Section 3 — Must be completed only by an appropriate Health Care Provider (MD, DO, APRN or PA).

I hereby certify that the above-named applicant is eligible for the Permit to Hunt From a Vehicle because of a PERMANENT mobility limitation as checked in Section 2, as per MCA 87-2-803(10)

\_\_\_\_\_  
PRINT — Provider Name

\_\_\_\_\_  
Provider — Office Phone Number

\_\_\_\_\_  
PRINT — Provider Address

\_\_\_\_\_  
License # of Health Care Provider

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

***In accordance with Section 87-2-803 (11) MCA code has been amended to read: The department or a person who disagrees with a determination of disability or eligibility for a Permit To Hunt From A Vehicle may request a review by the Board of Medical Examiners pursuant to 37-3-203.***